Suicidal Behaviour in French and Egyptian Patients Admitted to a Psychiatric Hospital

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The frequency of suicidal behaviour in the general population in France is considerably higher than that in Egypt. To investigate the frequency of such behaviour in a sample of psychiatric patients, all patients admitted to a French and an Egyptian hospital during a one month period were screened for suicidal behaviour. In the French patients, the frequency of suicidal behavior was found to be greater, with more violent methods used, and more frequent positive family history for such behaviour. This high frequency can be attributed to the absence of a "collective ego" and a greater sense of individual liberty.

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Introduction

Suicidal behaviour has been said to include suicidal thoughts, suicidal threats, suicidal attempts and suicide (Wilmotte et al., 1986). There appears to be no clear cut distinction between these different forms of suicidal behaviour or the profile of individuals manifesting one or the other, and Vuille and Seywert (1990) believe that these forms of suicidal behaviour should be considered a continuum.

The frequence of suicidal behaviour in western societies (e.g. France) is considerably higher than in more traditional countries (e.g. Egypt). The incidence of suicide in France is estimated to be 12500/year, i.e. 22% of total deaths (Montfort, 1990), and that of suicidal attempts is about 90000/ year (Marquet, 1990). As regards Egypt, Shaheen and Rakhawy (1971) quoted a W.H.O. report which regarded that the lowest suicide rate was in Egypt. Okasha (1984) reported that the results of a study in Cairo gave a rough estimate of 4 suicides /100,000 and 38 attempted suicides/100,000. In 1989,the official police record stated that there were a total of 96 deaths by suicide in all Egypt. It is obvious that statistics concerning suicidal behaviour, especially suicide, should be taken with caution (Davidson and Philippe, 1979; 1981), especially in countries such as Egypt where social and religious factors impede the declaration of suicide as the cause of death. Thus, official statistics are probably an underestimation. Nevertheless, they can give us a rough idea about the extent of such a problem and the difference in incidence between France and Egypt seems striking.

Many French authors have attempted to throw light on the high incidence of suicidal behaviour in the general population in France. A major turning point was the French revolution, before which suicide was vigorously denounced by the state and catholic church (which refused the burial of persons dying by suicide in church cemeteries). The progressive change in the attitude of State and Church appears to be a reflection of a changing society. The

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essential characteristic of this new society was its being individualistic (Thouvenin, 1986), and the supporters of this new society such as Voltaire proclaimed that suicide was an index of the liberty of the individual (Cordier et al., 1990). Suicide started to acquire a somewhat positive connotation, rather than being considered a sacrilege, a crime or illness (Molto and Tremine, 1990). One of the consequences of this increasing individualism and increasing sense of personal liberty was a more competitive and thus, a more intolerant society. Langlois (1976) postulated that the disabled, whether physically or mentally, the elderly and the as yet unproductive youth became outcasts and were eliminated in one way or another. suicide may be one such way.

Transcultural studies have attempted to explain the remarkable difference in incidence of suicidal behaviour between 'traditional' societies and 'developed' ones. Laplantine (1986) stated that the 'ego' in traditional societies is a social ego and not an individual one. It is an ego which lives a continuous osmotic exchange with the culture and with the cosmos. Olindo-Weber (1988), from her work on 'Black Africa', believed that the concept of a person in its communities is that of a subject who has adopted the boundaries of his group. The dimension of belonging is an essential pivot in the structure of the individual, the family and the race. The individual seems particularly refractory to suicide because there is congruence between individual and group tendencies. Bensmail et al. (1989), in their work on suicidal behaviour in Morocco, added that the individual is not only identified by his belonging to the group (collective ego), but also by his belonging to his ancestors (genealogic ego).

Religion has often been evoked as one of the protective factors against suicide (Durkheim, 1893). As regards Islam, Ghorbal (1981) stated that the word 'intahar' (suicide) is never explicitly mentioned in the Koran, although verses have been interpreted as prohibiting suicide. The prohibition of suicide is more clearly stated in 'al Hadith'. The author believed that though the prohibition of suicide has been related to the Islamic religion, the absolute character of this prohibition stems from the society. Similar remarks can be made as regards Christianity, where interpretation of the Bible is influenced by the prevailing social context.

An interesting question which arises is whether the incidence of suicidal behaviour in psychiatric patients in different cultures reflects a difference as striking as that in the general population. A global clinical impression is that suicidal behaviour in Egyptian psychiatric patients is less common than in French. This work attempts to probe this point.

Subjects and Method

All patients admitted during a one month period to a psychiatric hospital in both France and Egypt were screened for suicidal behaviour in the present illness or their past history. Suicidal behaviour was defined as suicidal ideas, suicidal attempts and successful suicide. The method used for the latter two was identified. In France, the hospital was Centre Hospitalize Specialize de Rennes (CHS) in one department corresponding to a specific geographical area. In Egypt, the hospital was Dar El Mokattam for Mental Health in Cairo. It must be noted that the comparison between the admissions in these two establishments is approximative due to the difference in health service organization in the two countries.

Demographic data was collected and each patient was given a diagnosis for

the current admission according to ICD-9 (the classification in common use in French hospitals) by a psychiatrist of more than 5 years experience.

Results

The total number of admissions in the CHS-Service Dr. Michelin during a one month period was 32, and the number of patients found to have suicidal behaviour in their present illness or past history was 13 (40.6%): 8 in the present illness, 7 in past history and 2 in both present and past illness. In the Egyptian hospital, the total number of admissions during a one month period was 65, and the number of patients with suicidal behaviour in present illness or past history was 11 (16.9%): 7 in the present illness, 7 in past history and 3 in both. These findings are shown in Table 1.

Table 1
Suicidal Behaviour in French and Egyptian Patients

	French hospital	Egyptian hospital
Total no. of admissions	32	65
Pts. with suic. behav. (present & past)	13 (40.6%)	11 (16.9%)
Pts. with suic. behav. in present illness	8	7
Pts. with suic. behav. in past illness	7	7
Pts. with suic. behav. in both present & past history	2	3

Table 2
Age of Patients with Suicidal Behaviour

Age	French patients		Egyptian patients	
	No	%	No	%
10-20	-	-	2	18.2
21-30	3	23.1	6	54.5
31-40	3	23.1	1	9.1
41-50	1	7.7	2	18.2
51-60	1	7.7	-	-
61-70	4	30.8	-	-
71-80	1	7.7	-	-

Table 3
Sex of Patients with Suicidal Behaviour

Sex	French patients		Egyptian patients	
	No	%	No	%
Males	2	15.4	6	54.5
Females	11	84.6	5	45.5

Table 4
Civil Status of Patients with Suicidal Behaviour

Civil status	French patients		Egyptian patients	
	No	%	No	%
Single	5	38.5	7	63.6
Married	5	38.5	4	36.4
Widowed	3	23	-	-
Divorced	-	-	-	-

Demographic data concerning the patients with suicidal behaviour are: shown in tables 2,3,4, and 5. The noteworthy findings as concerns the data are:

- The younger mean age of the Egyptian patients, and the absence of patients over 50 years in this group, whereas 6 French patients (46.2%) were over 50 years.

- The high proportion of females in the French group (84.6%) as compared to the Egyptian patients, where sex

Table 5
Occupation of Patients with Suicidal Behaviour

Occupation	French patients		Egyptian patients	
	No	%	No	%
Employed	3	23.1	5	45.4
Unemployed	4	30.8	1	9.1
Student	-	-	3	27.3
Housewife	6	46.1	2	18.2

Table 6
Type of Suicidal Behaviour in Present Illness and Past History for French and Egyptian Patients

	French patients				Egyptian patients			
	Present		Past		Present		Past	
	No	%	No	%	No	%	No	
Suic. thoughts	2	15.4	-	-	5	45.4	2	
Suic. attempt	6	46.2	7	53.8	2	18.2	5	
Suicide	1	7.7	-	-	-	-	-	

distribution was almost equal.

- The relatively high percentage of employed subjects and students in the Egyptian patients (45.4% and 27.3% respectively).

It should also be stated that in the French hospital, all our patients were of French nationality, and those in the Egyptian hospital were Egyptian.

The type of suicidal behaviour, whether thoughts, attempts or successful suicide in both present illness and past history for each group is shown in Table 6. It can be observed that in the present illness, 2 (15.4%) of the French patients had suicidal thoughts, 6 (46.2%) made a suicidal attempt and 1 (7.7%) committed suicide (by hanging himself during his hospitalization), as compared to 5 (45.4%) with suicidal thoughts, 2 (18.2%) with suicidal attempts and no successful suicide in the Egyptians. In their past history, 7 French patients

Table 7
Method Used in Suicidal Attempt or Suicide in Present Illness or Past History for French and Egyptian Patients

	French patients		Egyptian patients	
	Present	Past	Present	Past
Drug overdose	4	2	2	5
Drowning	2	3	-	-
Hanging	1	-	-	-
Strangulation	-	1	-	-
Phlebotomy	-	1	-	1
Jumping from heights	-	1	-	-
Suffoc. by gas	-	-	-	1

Table 8
Diagnosis for the Current Admission (ICD 9)

Diagnosis (ICD 9)	French patients		Egyptian patients	
	No	%	No	%
Manic-dep. illness	7	53.8	7	63.6
circular: dep. phase	3		1	
dep. form	3		2	
circular: manic phase	1		2	
circular: mixed	-		2	
Schizophrenia:	3	23.1	2	18.2
hebephrenic	2		-	
paranoid	1		1	
schizoaffective	-		1	-
Alcohol dependence	2	15.4	-	-
Anxiety states	1	7.7	1	9.1
Personality disorder with predominantly sociopathic or asocial manifestations	-		1	9.1

(53.8%) had suicidal attempts, and in the Egyptian group 5 (45.4%) had suicidal attempts and 2 (18.2%) had suicidal thoughts.

More than one form of suicidal behaviour or repetition of such behaviour were encountered in several cases. One French patient, in his present illness, made a suicidal attempt by drug overdose and later committed suicide by hanging himself. Another French patient had 2 suicidal attempts in her past history by drowning and phlebotomy. In the Egyptian group, one patient made more than 3 suicidal attempts by drug overdose in her past history, and another made 3 suicidal attempts (drug overdose, phlebotomy, gas) also in her past history.

The method used in the suicidal attempt or suicide (whether present or past history) is shown in Table 7. These methods included drug overdose, drowning, hanging, strangulation, phlebotomy, jumping from a window, and suffocation by gas. The more drastic measures (drowning, hanging, strangulation, jumping from a window) were encountered in the French patients but not in the Egyptian patients.

Family history was positive for suicidal behaviour in 3 of the French patients. One had a brother who died by shooting himself, one had her father who committed suicide (method unknown) and a grand-daughter who made 3 suicidal attempts; and the third patient had a brother who died by shooting himself and her mother and sister had suicidal thoughts. None of the Egyptian patients had a positive family history for suicidal behaviour.

The diagnoses of the patients for the admission in question, according to ICD 9 are shown in Table (8). It can be seen that in both groups, there was a relatively high percentage of manic-depressive patients (53.8% in the French and 63.6% in the Egyptians) and schizophrenics (23.1% in the French and 18.2% in the Egyptians). Alcohol dependence which is often found to be associated with suicidal behaviour in French studies was the diagnosis in 2 French patients.

Discussion

The older mean age group in the French patients, and the presence of 46.2% over 50 years can be explained by the increasing admission of elderly patients, in general, to French psychiatric hospitals, and also the frequence of suicidal behaviour, especially suicide, in French elderly patients (Choquet, 1989). The younger age of the Egyptian patients may explain the higher percentage of employed subjects and students.

The higher percentage of females in the French group may be related to the higher incidence of manic-depressive illness in females, but this does not explain why there was no sex difference in the Egyptians. A larger group would allow us to examine the frequence of suicidal behaviour in each sex more thoroughly.

The major finding is the higher frequence of suicidal behaviour in French patients admitted to a psychiatric hospital as compared to Egyptian patients. Although it is not possible to generalize these results, they seem to correlate with clinical observation in the two countries. Arafa (1978) found that 93% of depressive Egyptian patients had suicidal trends, but even he, observed that this high percentage was probably due to broad criteria for justifying the presence of the symptom and thus not a valid representation. Our study also shows that French patients more frequently chose more violent methods of suicide (drowning, hanging,

strangulation, jumping from heights), thus indicating perhaps a higher suicidal intent. Positive family history for suicidal behaviour in suicidal patients is also a common observation in France, one which may have given rise to hypotheses concerning the contribution of genetic factors to suicidal behaviour or that imitation plays a role in the etiology of suicide. It may, however, reflect that suicidal behaviour as a solution or mode of expression is found in certain families more than others.

The large percentage of major psychiatric disorders (manic-depressive illness and schizophrenia) indicates that suicidal behaviour in patients admitted to psychiatric hospitals is often in the context of these illnesses, whereas patients with less serious pathology or no psychiatric illness at all are seen in emergency services, or in general hospitals.

It appears possible, within the limitations of this study, to confirm that suicidal behaviour in psychiatric patients admitted to a psychiatric hospital in Egypt is less common than that in France, thus reflecting the frequence of such behaviour in the general population in each of the two countries. It is interesting to speculate that psychiatric disorders, even if universally similar in symptomatology and perhaps psychopathology, nevertheless manifest certain differences in various socio-cultural contexts. The 'sense of belonging' and 'collective ego' presumed to protect individuals in more traditional cultures against suicide in the society at large, also apparently protect psychiatric patients, even psychotics. Therefore, the disorder is manifested otherwise, perhaps by other self-destructive behaviour which does not lead to severing the ties between individual and group.

In conclusion, it must be observed that these presumed trends of relatively low suicidal behaviour whether in the general population or in psychiatric patients in traditional societies may be changing. Laplantine, in 1986, warned that with changes in society, the discovery of 'individualism' can be a dramatic experience and may lead to a spectacular increase in the frequence of suicide in such societies.

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Les conduites suicidaires chez les patients psychiatriques Français et Egyptien hospitalisés

Le taux annuel des conduites suicidaires dans la population générale en France est beaucoup plus élévé qu'en Egypte. Nous avons comparé la fréquence des conduites suicidaires chez les patients admis dans un hôpital psychiatrique en France et un autre en Egypte pendant un mois. La fréquence des conduites suicidaires chez les patients français était plus élevée, ils avaient tendance à utiliser des méthodes plutôt violentes et leurs antécédents familiaux pour les conduites suicidaires étaient plus fréquents. Ces resultats pourraient être attribuer à l'absence de ce que l'on peut appeler "un moi collectif " ainsi qu' un sens plus grand de liberté individuelle.

السلوك الإنتحارى عند المرضى الفرنسيين والمصريين فى مستشفيات الامراض النفسية

إن نسبة حدوث السلوك الانتحارى فى فرنسا اكثر بكثير منها فى مصر. ولبيان تواتر هذا السلوك عند المرضى النفسيين تمت دراسة حالات الدخول فى فترة شهر فى مستشفى امراض نفسية فى فرنسا وأخرى فى مصر لتحديد مدى وجود هذا السلوك الإنتحارى. وقد وجدنا أن تواتر هذا السلوك عند المرضى الفرنسين أعلى منه عند المصريين واستخدم الفرنسيون وسائل للانتحار اكثر عنفاً.

ويمكن تفسير ذلك بغيبة " أنا جماعية " وتضخم الشعور بالحرية الفردية لدى الفرنسيين.

Depressive Symptomatology in Preschool Children

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The present study has attempted to identify the depressive symptomatology in preschool children, their possible contributing factors and the parental attitude to their presence. 30 children (15 from each sex) aged 4 to 6 years had been referred from a senior psychiatrist after being diagnosed as having depressive symptomatology. Each child was subjected to thorough medical and neurological examination to exclude organic lesions and to a semistructured psychiatric interview based on DSM III-R criteria. A control group formed of 30 children was selected from MCC center in Kalaa and matched for age, sex and socioeconomic standards. Both groups were subjected to the same procedures. A questionnaire to study the parental attitude was applied to parents of both groups. 40% of the sample had dysthymic disorder, 10% of males only had adjustment disorder with depressed mood. While 6.7% of females had major depressive symptoms were sad facial appearance, unhappiness, aggressive behavior, sleep and speech disorders. Affective disorders were evident in 46.7% of the mothers, 43.3% of fathers of the sample. Results revealed that depression in preschool children was not uncommon, there are some precipitating factors that render children more vulnerable to suffer from this disorder.

The authors advised to give importance to the primary prevention approach to help preschoolers and their parents to properly handle depressive symptoms.

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Introduction

Depression in children and adolescents was previously uncommon, but this concept now has been corrected (McConville, 1983). It became a topic of considerable research interest in the last decade (Angold, 1988). One of the first tasks of the investigations in this area has been establishing uniformity in what is meant by depression. Goodyear et al (1991) confirmed recent reports that the outcome of depression in school age children and adolescents was poor, with up to 50% of the children reported as having persistent or relapsing symptoms. So the current study has attempted to identify the depressive symptoms in preschool children to study the possible

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contributing factors and to test the effect of parental attitudes by psychometry as a cofactor in the psychopathology of depression in childhood.

Estimation of the prevalance of affective disorders in children varied from 0% (Makita, 1970) to more than 50% (Carlson and Cantwell, 1979). Several studies have suggested that depression is common in school age children and adolesents (Malmaquist, 1983). Recently, attention was directed towards depressive symptoms in preschool children. Kasheni et al (1986) provided evidence that major depressive disorder exists in preschoolers and the stressful life events are associated with these symptoms. Cytryn and McKnew (1972) proposed classification system which considers severity as well as aetiology. Frommer (1968) differentiated the childhood depression into enuretic, phobic, pure and manic depression.

Several studies have largely focused on mothers with concurrent depression as a predisposing in childhood depression (Cox et al., 1987; Alanstein et al., 1991). Kosky et al., (1990) were unable to differentiate children with suicidal thoughts from those attempted suicide on the bases of clinical symptoms alone.

Subjects and Method

The sample comprised 30 children (15 males and 15 females) 4 - 6 years old (preschool age) with depressive symptoms who were chosen from the outpatient psychiatric clinic of Ain Shams and Abou El Rish paediatric hospital. A control group of 30 healthy children who were matched for age, sex and social class. They were chosen from the attenders of EL Kalaa Maternal and childhood care center.

Every child was subjected to thorough medical examination including neurological assessment, a semistructured psychiatric interview based on DSM III-R criteria (1987). The parents of the children were called for another semistructured interview to give details about antenatal, natal and postnatal developmental status of the child, data related to the family and to detect the depressive symptoms of their children. Also, the parents were y lded to the parental attitude questionnaire (Esmaail and Fam, 1964).

Results

Psychodemographic data showed that 63.3% of the study group were 5 - 6 years old, while 36.7% were 4 - 5 years old. 53.3% of the sample were the middle in their families, 33.3% were the eldests in order compared to 30% and 60% were the eldests in order compared to 30% and 60% of the control group five members compared to 23.3% of controls (x^2 = 6.02, P> 0.05. insig.). Most of the study and control group were belonging to social class IV and V.

Table 1
Shows t-test of Parental Attitudes was non Significant Except Spoiling Attitude was Significant

Symptom	Depressed		Control		Statiscial significance		
	No	%	No	%	x^2		
Behavior							
- aggressive	20	66.7	4	13.3	28.8	P <0.01	Sig
- submissive	10	33.3	8	26.7			
Sad unhappy mood	30	100	1	3.3	56.1	P <0.01	Sig
Sychomotor							
hyperactivity	19	63.3	6	20	41.8	P <0.001	highly sig
hypoactivity	11	46.7	-	-			
Decreased appetite	21	70	13	43.3	5.9	P <0.05	Not sig
Insomnia	17	56.7	2	6.7	19.2	P <0.001	highly sig
Speech disorder							
- normal	11	36.7	30	-	27.8	P <0.001	highly sig
- verbalized dysphonia	16	53.3	-	-			
- delayed speech	3	10	-	-			

Table 2
Psychological Assesment Results of Parental Attitudes Criterion

Attitudes	Depressed		Control		t-test	df	P
	Mean	S.D±	Mean	S.D±			
- Domination	48.22	16.84	45.31	18.77	0.62	58	>0.05
- Overprotection	50.56	21.90	50.43	18.64	0.043	58	>0.05
- Negligence	34.29	19.92	31.03	15.49	0.69	58	>0.05
- Spoiling	37.17	18.27	25.16	16.32	2.64	58	<0.05
- Cruelity	33.8	26.58	29.66	18.89	0.68	58	>0.05
- Indcing Psychological Pain	33.6	14.08	42.88	17.26	0.174	58	>0.05
- Hesitation	66.3	16.267	68.5	18.39	0.483	58	>0.05
- Discrimination	35.17	30.81	30.43	15.79	0.738	58	>0.05
- Normality	57.68	10.21	61.3	11.69	0.438	58	>0.05
Telling lies	44.2	20.3	52.5	16.65	1.7	58	>0.05

36.7% of the study group were not wanted child compared to 3.3% of controls (x^2 = 9.45. p< 0.01 sig.). Also, 53.3% compared to 13.3% were not wanted sex (x^2 = 10.8 p>0.01 sig.). As regards mother attitude towars nursing; acceptance, rejection, and indifference were recorded in the study and control group in frequencies of 53.3%, 20%, 26% compared to 96.7%, 0.0%, 3.3% respectively (x^2 = 13.18, p> 0.01 sig).

Affective disorder was evident in 46.7% of the mothers of the sample compared to 10% of those of the control group (x^2 = 9.9, p> 0.01 sig). While it was present in 43.3% of the fathers of the sample compared to 16.7% of the control (x^2 = 5.06, p> 0.05 sig.). It was found that aggressive behavior was the commonest behavior among depressed children, in 66.2% compared to in control group (x^2 = 28.8, p < 0.001 highly sig.). Hyperactivity was found in 63.3%, while hypoactivity in 36.7% compared to 20%, 0.0% in the control group respectively (x^2 = p < 0.001 highly sig.). 70% had appetitechanges, while 56.7% suffered from insomnia compared to 6.7% of the control group (x^2 = 19.24, p < 0.001 highly sig.). 40% of the sample had dysthymic disorder. 10% of males and 6.7% of females presented with adjustment disorder with depressed mood and major depression respectively. The rest of children had depressine symptoms not sufficient to be diagnosed as a disorder.

* Parental attitudes criterion by Prof. Dr. Mohamed Emad El-Dine Esmayl. Ass. Prof. of Psychology, Ain Shams University, and prof. Dr. Roshdy Fam Ass. prof. of Psychology, Ain Shams University, 1964

Discussion

The preschool years are remarkable of dramatic growth, physical, affective and cognitive development. Major themes in affective development include the achievement of impulse control and socialization skills (Dwarkin, 1988). Signs and symptoms of childhood depression are different from those seen in adults and vary with different age levels. The syndrome must be recognized as early as possible to prevent chronic illness from developing, as it can cause serious difficulties in academic life, can affect relations with peers and can lead to serious delinquent behavior and sexual disorders (Dolgan, 1990). Rubin et al (1989) suggested that social withdrawal in early childhood may be predictive of risk for internalizing difficulties in later childhood. In a prospective and comprehensive evaluation including DSM III diagnosis of 1000 preschoolers in a child development unit, nine children were found to meet the criteria for major depressive disorders (Kashani and Carlson, 1987).

In the current study two female cases were found to meet DSM III criteria of major depressive disorder. Carlson and Kashani (1988) found that the frequency of depressive symptoms was compared

in prepubertal children (N=95), adolesents (N=92) and adults (N=100). Symptoms of depressed mood, lack of concentration, insomnia and suicidal ideation oocurred with similar frequencies across this developmental span. The authors concluded that age modifies symptom's frequency but does not alter basic phenomenology.

Distinctions have to be made between depressive symptoms that are transient and those symptoms that represent clinical disorders such as bipolar disorders, cyclothymia, dysthyma, and major depressive disorder. The clinically sensitive physician attuned to the diagnostic criteria of these disorders has the opportunity to promote effective treatment and reduce morbidity associated with these conditions (Show, 1988).

In the present study there was a significant percent of depressed children who had insomnia (56.7%), on the contrary appetite changes were present in both groups and the difference was statistically insignificant.

Puig-Antich et al., (1982) conducted all night sleep EEG studies on depressed children, did not distinguish charecteristics between children with major depressive disorder and either children with neurotic depression or normal children. 53.3% of our cases verbalized dysphoria. Cytuyn and McKnew (1979) found that verbal expression of depressed children, feeling hopless and helpless, being unattractive, unloved are common. Younger children; 5-8 years old verbalized feeling of sadness more directly, while older children 8-12 years are more likely to show increasingly poor self-esteem (Toolen, 1981). In our study aggressive behavior (66.3%) and hypoactivity was recorded in 36.7% only of the sample. Findings reported by Biederman et al (1989) support the hypothesis that DSM III attention deficit disorder and major depressive disorder sare common familial vulnerabilities. Analysis of the results show that affective disorder of parents was highly significant. Depression can refer to either depressive symptoms or diagnosable depression, depression among mothers occur frequently, was persistent.

Studies demonstrated an association between mother's depression and adverse outcome for her children including the affective illness (Zuckerman and Beardslee, 1987). Alanstein et al (1991) studied the relationship between postnatal depression in mother child interaction, index mother child pairs showed a reduced quality of interaction. In the present study unwanted child, unwanted sex and mother's attitude towards nursing before illness might predispose or trigger to exhibit depression in those children. Parents might not be aware of internal emotions and cognitive symptoms in their children as they were of observable changes in their behavior (Goodyear et al., 1991). The present study could identify the impact of age on the occurrance of depression in preschoolers. it coined that it was more prevalent in older children aged more than five years (63.3%) than younger children aged four years (36.7%) in a ratio of 1:0.8. Angold (1988) provided support for our results. Our study failed to find differences between sample and control group as regards parental attitude and the development of depression except on spoiling which was more prevalent in depressed children. This may reflect the way of dealing with emotional problems.

Conclusions and Recommendations

The present study could reach that the depression in preschoolers is becoming widely spread, and that there are some precipitating factors rendering the children more vulnerable to suffer from this

disorder. From this point, the research advices the primary prevention approach to focus on preschoolers and their parents who are at risk.

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Symptomatologie Dépressive chez les Enfants d'Age préscolaire

Cette étude vise à identifier la symptomatologie dépressive chez les enfants d'âge préscolaire, les facteurs contribuant ainsi que les attitudes parentales à leur égard.

Le groupe étudier était constitué de 30 enfants (15 de chaque sexe) agés de 4 à 6 ans, adressés par le psychiatrie après avoir identifié chez eux une symptomatologie dépressive.Les enfants ont passé un examen médical et neurologique approfondi afin d'éxclur les pathologies organiques ainsi qu'un entretient psychiatrique semistructuré basé sur les critères du DSMIII-R. Un groupe control de 30 enfants a été sélectionné et parié pour l'âge, le sexe et le statut socioéconomique. Un questionnaire pour évaluer les attitudes parentales a été utilisé avec les parents des enfants des deux groupes. Nos résultats ont montré que la dépression chez les enfants d'âge préscolaire était assez fréquente, quelques facteurs précipitant rendaient les enfants plus vulnérable à ce trouble.

L'auteur suggère de donner de l'importance à la prévention primaire afin d'aider les enfants d'âge préscolaire ainsi que leurs parents à faire face à ce problème.

الأعراض الإكتئابية فى أطفال ما قبل المدرسة

تهدف هذه الدراسة للتعرف على أعراض الاكتئاب فى الأطفال فى سن ما قبل المدرسة والعوامل المؤدية لوجود هذه الأعراض بالإضافة إلى موقف الوالدين لوجودها.

وقد اشتملت هذه الدراسة على ٣٠ طفلاً فى سن ٤ - ٦ سنوات من المحولين للطبيب النفسى بسبب وجود أعراض اكتئابية. وقد تم تقويم كل طفل طبياً وعصبياً لإستبعاد الأسباب العضوية وخضع كل طفل لمقابلة طبيه نفسيه شبه مقننة حسب دليل التشخيص الاحصائى الأمريكى الثالث المراجع. وقد تم تقويم عينة ضابطة متماثلة فى الجنس والسن والمستوى الاقتصادى والاجتماعى من مركز رعاية الطفولة والأمومة.

وقد تم دراسة موقف الوالدين من خلال استبيان طبق على مجموعتى الأطفال؛ وأظهرت النتائج أن ٤٠٪ من العينة المحوله يوجد لديها إضطراب عسر المزاج، ١٠٪ من الأطفال الذكور يوجد لديهم اضطراب التأقلم مع مزاج اكتئابى، أما الأطفال الاناث فيوجد لدى ٦٠٧٪ منهم أعراض الاكتئاب الجسيم مع مظاهر الحزن على الوجه والسلوك العدوانى واضطرابات النوم والكلام، وقد ظهرت الاضطرابات الوجدانية فى ٤٦٠٧٪ من أمهات الأطفال و ٤٣٣٪ من أبائهم، وتشير النتائج إلى أن الاكتئاب يوجد فى أطفال ما قبل المدرسة بصورة غير قليله وأن هناك بعض العوامل التى تؤدى إلى المعاناه من هذا الاضطراب ويناقش الباحثون أهمية الوقاية النفسية الأولية لأطفال سن ما قبل المدرسة ووالديهم للتعامل مع هذه الأعراض.